Houston Center for
Maternal Fetal Medicine
an affiliate of MEDNAX

Genetic/Family History Questionnaire

Patient Name: _______________________________________Date of Birth: ___________________Date: _____________

How would you describe your ancestry? Please check all that apply.

☐ White	☐ French Canadian	☐ Samoan	☐ Vietnamese
☐ African (Black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeastern Asian
☐ Guamanian	☐ Hawaiian	☐ Asian- East Indian	☐ Unknown Race

☐ Other: ____ ☐ Other: ____________________________________

Are you and the father of this baby a blood relative (i.e. cousins)? Yes ______ No ______

What is your occupation? ____

What is the name of the father of this baby? ____

What is the occupation of the father of this baby? ___________________________________

What is the age of the father of this baby? ____

How would you describe the ancestry of the father of this baby? Please check all that apply.

☐ White	☐ French Canadian	☐ Samoan	☐ Vietnamese
☐ African (Black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeastern Asian
☐ Guamanian	☐ Hawaiian	☐ Asian- East Indian	☐ Unknown Race

☐ Other: ____ ☐ Other: ____________________________________

Is the father of this baby your partner? Yes ______ No ______

Is this pregnancy a Product of IVF? Yes ______ No ______ If yes:

Was a donor egg used? Yes ______ No ______

What is the age of the donor? ______________________

Comments: ____

____

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Revised 09/2019

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Do you or the father of this baby, or any close relatives have:

Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80	☐ Yes	☐ No
Neural Tube Defect (Meningomyelocele Spina Bifida or Anencephaly)	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Down syndrome	☐ Yes	☐ No
Tay-Sachs (Jewish, Cajun, French Canadian)	☐ Yes	☐ No
Sickle Cell Disease or Trait (African)	☐ Yes	☐ No
Hemophilia or Bleeding Problems	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Canavan Disease	☐ Yes	☐ No
Mental Retardation / Autism / Learning Disorder	☐ Yes	☐ No
If Yes, Tested for Fragile X	☐ Yes	☐ No
Huntington Chorea	☐ Yes	☐ No
Other inherited Genetic or Chromosomal Disorder	☐ Yes	☐ No
Maternal Metabolic Disorder (insulin Dependent Babies, PKU)	☐ Yes	☐ No
Patient or Baby's father had a child with birth defects NOT listed above?	☐ Yes	☐ No
If yes, describe ____		
Recurrent pregnancy Loss or Stillbirth	☐ Yes	☐ No
Blindness or Deafness	☐ Yes	☐ No
Bone or Skeletal Disorder (Dwarfism)	☐ Yes	☐ No
Breast, Ovarian, Or Colon Cancer	☐ Yes	☐ No
Kidney Disorder	☐ Yes	☐ No
Do either of you or any of your parents, siblings or children have Diabetes?	☐ Yes	☐ No
Blood/Clots / Stroke	☐ Yes	☐ No
Have you taken any medications other than Prenatal Vitamins since pregnancy?	☐ Yes	☐ No
Have you used any street drugs since becoming pregnant?	☐ Yes	☐ No
If yes, please list substance: ______________________ How often? __________		
Have you consumed any alcoholic beverages since becoming pregnant?	☐ Yes	☐ No
If yes, please list substance: ______________________ How often? __________		
Do you currently smoke?	☐ Yes	☐ No
Anything else that runs in the family? ___________________________________	☐ Yes	☐ No

Comments: ____

____

Reviewed By: ____

Revised 09/2019

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Review of Systems Questionnaire

Have you been screened to see if you are a carrier for inherited diseases such as **cystic fibrosis, thalassemia, sickle cell trait, spinal muscular atrophy (SMA), or Fragile X?** Yes ______ No ______

If so, are you a carrier of any known inherited disease? Yes ______ No ______

If yes, which one(s)? ____

Have you or your partner travelled to Florida this pregnancy, or anywhere outside the United States?
Yes ______ No ______

If yes, where and when? ____

Do you have a history of preeclampsia in any previous pregnancy? Yes ______ No ______

Preferred Pharmacy: _______________________________________ Phone Number: __________________________

Do you or have you taken medication in the last year?

Medications Taken	Dose	Frequency	Date Started

Do you have any known drug allergies?

Drug	Reaction	Severity (mild, moderate, or severe)

Review of Systems Questionnaire

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Do you have a past or current history of any Psychiatric Disorders, Depression, or Postpartum Depressions?

Yes _______ No _______ If yes, please state the condition(s) and when diagnosed.

Date	Condition

Do you have any medical problems (Example: Diabetes, High Blood Pressure, Thyroid)?

Medical Issue	Date

Past Surgeries: (Example: Appendectomy, Cervical Colonization, LEEP, Laparoscopy, Hysteroscopy)

Surgery	Date

Previous Pregnancies:

Year	**Outcome** (full term, preterm, miscarriage, termination)	**Gestational Age** (# of Weeks at delivery)	**Type of delivery** (vaginal cesarean, forceps, vacuum)	Weight and Gender	Complications

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Obstetrix Medical Group of Houston will transmit my prescriptions electronically as permitted, to the pharmacy that I delegate as my primary pharmacy provider. Additionally, Obstetrix Medical Group of Houston will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record.
E-Prescribing greatly reduces medication errors and enhances patient safety.
Features of our ePrescribe program include:

- Formulary and benefit transactions- Provides us with information about which drugs are covered by the drug benefit plan.
- Medication history transactions- Provides us with information about medications you are already taking.
- Fill status notification- Sends us an electronic notice that your prescription has been picked up.

By signing this consent form you are agreeing that we can ePrescribe for you and request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

☐ I hereby provide informed consent to enroll me in the ePrescribe program.

☐ I decline this option. I do not give permission for access to the above information.

Pharmacy Information

Pharmacy Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

______________________________ ______________________________
Signature of Patient or Legal Representative **Date**

IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

What is Ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam is a series of pictures of the baby and organs in the mother's pelvis.

Is Ultrasound safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power and frequency is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

Does a normal Ultrasound prove that my baby will have no abnormalities?

Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby and the baby's organs but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy." Abnormalities of brain function such as mental retardation cannot be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can Ultrasound determine if there are chromosomal abnormalities?

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities, either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

________________________________ ______________________

Patient/Guardian signature Date

________________________________ ______________________

Printed Name Date of Birth

Houston Center for Maternal Fetal Medicine

Patient Registration Form

PATIENT INFORMATION

How well do you speak English? ____Very Well ____Well ____Not Well ____Not At All

Name (First, Middle, Last) ____Date of Birth: __________

Mailing Address: _____________________________________City, State, Zip: ___________________________

Tel#: ________________________________Alt#:_____________________Email: ________________________

Social Security Number: _________________ Marital Status: Single ____ Married_____ Divorced____ Widowed____

Patient Employer: ___________________________________ Work Phone: _____________________________

SPOUSE/GUARDIAN INFORMATION

Name: ____ Date of Birth: ________________

Social Security Number: _________________Relationship to Patient: _______________ Tel#: __________________

Employer: ______________________________ Work Phone number: ________________________

EMERGENCY INFORMATION

Name: ____ Tel#:: __________________________________

PATIENT RESPONSIBILTY

I authorize the release of any medical records or other information necessary to process my insurance claims on my behalf. I authorize Obstetrix Medical Group of Houston to appeal all insurance claims as appropriate on my behalf. I agree to be fully responsible for all lawful debits incurred by myself for services whether or not covered by insurance.

Signature: ____ Date: ______________________________

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Policy on Children

Our practice is committed to family-centered care and welcomes family members at routine clinic visits. To ensure that our staff members can devote their undivided attention to each patient, if you will be bringing a child under the age of 10 to your appointment, please also bring another adult to provide supervision during your examination, procedures or critical discussions.

Viral and infectious diseases, common in children, can be harmful to the fetus in early pregnancy. To protect our patients and their unborn babies, please refrain from bringing a child to your appointment who is exhibiting any signs of illness, including coughs, cold symptoms or fever.

Please sign below to acknowledge that you have read and understand our policy.

Signature: ____

Date: ____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@pediatrix.com** or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_______________________________________ ____________
Signature of Patient or Authorized Representative Date

____
Print Name of Patient/Authorized Representative

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ASSIGNMENT OF BENEFITS

This Assignment of Benefits allows Pediatrix Medical Group to be paid directly by my health insurance carrier for medical services rendered by its providers. By signing this I assign and transfer to Pediatrix Medical Group all rights, title and interest in all benefits payable for the services rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. I hereby designate Pediatrix Medical Group to act as my representative during insurance or plan benefits appeal in the event of a coverage limitation or denial. I understand that Pediatrix Medical Group has the right to decline or accept this designation at the time a limitation or denial is received. The outcome of any appeal is not guaranteed and I understand that I may be responsible for any charges that remain unpaid by the insurance or benefit plan regardless of the outcome of any appeal. I have read this assignment of benefits, and I have signed this document freely and without inducement.

Insurance Policy Holder Name ____

Insurance Policy Holder Signature____

Signature Date______________________________

CESIÓN DE BENEFICIOS

La presente Cesión de Beneficios permite que Pediatrix Medical Group sea pagado directamente por mi asegurador médico por los servicios médicos provistos por sus proveedores. Con mí firma en el presente documento, cedo y transfiero a Pediatrix Medical Group todos los derechos, título e interés en todos los beneficios pagaderos por los servicios provistos, que sean dispuestos en todas y cualesquier pólizas de seguro y planes de beneficios médicos de los cuales mis dependientes o yo tengamos derecho a recuperar.

Por este medio designo a Pediatrix Medical Group para que actúe como mi representante durante apelaciones de seguro o planes de beneficios en caso de una limitación o rechazo de cobertura. Entiendo que Pediatrix Medical Group tiene el derecho de rechazar o aceptar esta designación en el momento del recibo de una limitación o rechazo. No se garantiza el resultado de cualquier apelación y entiendo que podré ser responsable de cualesquier cargos que quedasen sin pagar por el plan de seguro o beneficios, sin importar el resultado de cualquier apelación. He leído la presente cesión de beneficios y he firmado el presente documento voluntariamente y sin aliciente alguno.

Nombre de titular de la póliza de seguro ____

Firma del titular de la póliza de seguro ____

Fecha de la firma ______________________________

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, time, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA- compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1.____

2.____

3.____

4.____

Yes______ **No**______ The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staffs have my permission to leave messages concerning treatment (i.e. Lab Results) on my: (Please check all that apply)

_____ Home Voicemail/Answering machine   Home Phone number: ______________________________

_____ Cellphone   Cell Phone number: ________________________________

_____ Work voicemail   Work Phone number: _______________________________

_____ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

____   ____

Print Name of Patient   *Print Name of Authorized Representative

____   ____

Patient/Authorized Representative Signature   Date Signed

Authorized Representative's authority to act on the Patient's behalf:

☐Parent/legal guardian   ☐Power of Attorney

*Evidence of Authority must be provided and on file with the practice.

COMPLY.PRI.018.001 Rev.Date 04/08/2019